



## Quarterly Doses Administered Report

For FQHC / RHC Provider use

VFC PIN
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2. Clinic Name		Phone #	
Name of Person Submitting Form		Quarter / Year	
3. I certify under penalty of law that the below information is true.	Signature		Date

### Instructions for Completing the Quarterly Doses Administered Report

Complete and submit this form to the Utah VFC Program within 15 days following the end of each quarter.

<b>1<sup>st</sup> Quarter:</b>	January, February, March	Due <b>April 15<sup>th</sup></b>
<b>2<sup>nd</sup> Quarter:</b>	April, May, June	Due <b>July 15<sup>th</sup></b>
<b>3<sup>rd</sup> Quarter:</b>	July, August, September	Due <b>October 15<sup>th</sup></b>
<b>4<sup>th</sup> Quarter:</b>	October, November, December	Due <b>January 15<sup>th</sup></b>

1. Enter VFC Pin. (Verify if unsure of correct number.)
2. Print the clinic name, phone number, quarter and year of this report, and name of the person completing this form.
3. Read the attestation statement, sign and date. (Forms will not be accepted without signature.)
4. On the Total Number of Patients Vaccinated table, enter the number of VFC eligible children who received vaccines, by age and eligibility categories. **Total** each row and column.
5. Page two (reverse side), print clinic name and VFC Pin in top boxes. (When faxed, pages are separated.)
6. On the Total Number of VFC Doses Administered table, enter the number of doses administered to VFC eligible children, by age and vaccine type. **Total** each row and column.
7. On the Total Number of CHIP Doses Administered table, enter the number of doses administered to CHIP enrolled children, by age and vaccine type. **Total** each row and column.

**Use of Doses Administered Tally Sheet is Optional.**  
**Please do NOT return Tally Sheets.**

Mail or fax the Quarterly Doses Administered Report to:  
 Utah Department of Health  
 Immunization Program  
 PO Box 142001  
 Salt Lake City, UT 84114-2001  
 (801) 538-9450  
**FAX: (801) 538-9440**

4. Total Number of <b>Patients Vaccinated</b>						
Age	Vaccines for Children (VFC)				State Supplied	TOTAL
	Am. Indian/ Alaskan Nat.	Medicaid	Non-insured	Underinsured	CHIP	
<1						
1-6						
7-18						
>18						
<b>Total</b>						

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5. Clinic Name	VFC Pin
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6. Total Number of **VFC Doses** Administered[illegible]6. Total Number of **CHIP Doses** Administered (State Supplied)[illegible]